UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

PROLASTIN, **ZEMAIRA** (alpha-1-proteinase inhibitor)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and opt_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- **DOCUMENTED** Alpha-1 Antitrypsin deficiency **AND**
- **DOCUMENTED** Panacinar Emphysema
- Must have stopped smoking for at least 30 days, as documented by physician.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

9/15/06